PHYSICIAN'S REPORT FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY(RCFE)

I. FACILITY INFORMATION *(To be completed by the licensee/designee):*

1. NAME OF FACILITY:				2. TELEPHONE:
3. ADDRESS: NUMBER:	STREET:		CITY:	ZIP CODE:
4. LICENSEE'S NAME:		5. TELEPHONE:		6. FACILITY LICENSE NUMBER:

II. RESIDENT INFORMATION *(To be completed by the resident/resident's responsible person/licensee):*

1. NAME:	2. SOCIAL SECURITY NUMBER:	3. BIRTH DATE/AGE:

4. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION *(To be completed by resident/resident's legal representative)*

I hereby authorize release of medical information in this report to the facility named above.

5. SIGNATURE OF RESIDENT AND/OR RESIDENT'S LEGAL REPRESENTATIVE	6. ADDRESS	7. DATE

III. PATIENT'S DIAGNOSIS *(To be completed by the physician):*

NOTE TO PHYSICIAN: The person named above is either a resident or prospective resident of a residential care facility for the elderly licensed by the Department of Social Services. The license requires the facility to provide primarily non-medical care and supervision to meet the needs of that person. THESE FACILITIES DO NOT PROVIDE SKILLED NURSING CARE. The information that you provide about this person is required by law to assist in determining whether the person is appropriate for care in this non-medical facility. It is important that all questions be answered. *(Please attach separate pages if needed.)*

1. DATE OF EXAM:	2. SEX:	3. HEIGHT:	4. WEIGHT:	5. BLOOD PRESSURE:
6. TUBERCULOSIS EXAMINATION RESULTS: ☐ Active ☐ Inactive ☐ No Evidence of Disease				7. DATE/TYPE OF TB TEST:
8. TB TREATMENT USED, IF APPLICABLE:				

9. PRIMARY DIAGNOSIS:	10. TREATMENT/MEDICATION (TYPE AND DOSAGE)/EQUIPMENT:	11. CAN PATIENT MANAGE OWN TREATMENT/MEDICATION/EQUIPMENT? IF NOT, WHAT TYPE OF MEDICAL SUPERVISION IS NEEDED?
12. SECONDARY DIAGNOSIS(ES):	13. TREATMENT/MEDICATION (TYPE AND DOSAGE)/EQUIPMENT:	14. CAN PATIENT MANAGE OWN TREATMENT/MEDICATION/EQUIPMENT? IF NOT, WHAT TYPE OF MEDICAL SUPERVISION IS NEEDED?
15. CONTAGIOUS/INFECTIOUS DISEASE:	16. TREATMENT/MEDICATION (TYPE AND DOSAGE)/EQUIPMENT:	17. CAN PATIENT MANAGE OWN TREATMENT/MEDICATION/EQUIPMENT? IF NOT, WHAT TYPE OF MEDICAL SUPERVISION IS NEEDED?
18. ALLERGIES:	19. TREATMENT/MEDICATION (TYPE AND DOSAGE)/EQUIPMENT:	20. CAN PATIENT MANAGE OWN TREATMENT/MEDICATION/EQUIPMENT? IF NOT, WHAT TYPE OF MEDICAL SUPERVISION IS NEEDED?
21. OTHER CONDITIONS:	22. TREATMENT/MEDICATION (TYPE DOSAGE)/EQUIPMENT:	23. CAN PATIENT MANAGE OWN TREATMENT/MEDICATION/EQUIPMENT? IF NOT, WHAT TYPE OF MEDICAL SUPERVISION IS NEEDED?

24. PHYSICAL HEALTH STATUS:	YES	NO	ASSISTIVE DEVICE:	COMMENTS:
a. Auditory Impairment				
b. Visual Impairment				
c. Wears Dentures				
d. Special Diet				
e. Substance Abuse Problem				
f. Bowel Impairment				
g. Bladder Impairment				
h. Motor Impairment				
i. Requires Continuous Bed Care				

25. MENTAL CONDITION:	YES	NO	COMMENTS:
a. Confused/Disoriented			
b. Unable to follow Instructions			
c. Depressed			
d. Unable to Communicate Own Needs			
e. Unable to Leave Facility Unassisted			

26. CAPACITY FOR SELF-CARE:	GOOD	FAIR	POOR	COMMENTS:
a. Ability to Care for All Personal Needs				
b. Ability to Bathe Self				
c. Ability to Dress Self				
d. Ability to Feed Self				
e. Ability to Care for Own Toileting Needs				
f. Ability to Walk without Equipment or Other Assistance				

27. MEDICATION MANAGEMENT:	YES	NO	COMMENTS:
a. Can Administer Own Medications			
b. Can Store Own Medications			

28. AMBULATORY STATUS:

* **"Nonambulatory":** means persons who are unable to leave a building unassisted under emergency conditions because: 1) they are unable, or are likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or an oral instruction relating to fire danger; or 2) they depend upon mechanical aids such as crutches, walkers, and wheelchairs. (**NOTE:** A person who uses a cane is not considered nonambulatory.)

** **"Bedridden":** means persons who are unable to leave a building unassisted under emergency conditions and who also require assistance in turning and repositioning in bed.

a. This person is considered: ☐ Ambulatory ☐ Nonambulatory* ☐ Bedridden**

b. If resident is bedridden, what is the cause? *(Check one and describe nature of illness, surgery or other cause)*

EXPLANATION:

☐ Temporary Illness_____

☐ Recovery from Surgery_____

☐ Other_____

c. How long is bedridden status expected to persist? _____days

29. PHYSICAL HEALTH STATUS: ☐ Good ☐ Fair ☐ Poor

30. COMMENTS:

31. PHYSICIAN'S NAME AND ADDRESS (PRINT):

32. PHYSICIAN'S SIGNATURE: | 33. DATE:

34. TELEPHONE: ( ) | 35. LENGTH OF TIME RESIDENT HAS BEEN UNDER YOUR CARE: